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ADDRESS ON " IRIDO-CYCLITIS " *

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MR. PRESIDENT, LADIES AND GENTLEMEN,—I need not say how much pleasure it gives Mr. Caddy and I, and others who will show you the work of the Hospital, to see you here, and I hope we shall be able to interest you ; because this is work which requires close observation, it is not easy to show you things which interest you unless you are heavily engaged in ophthalmic work. I shall show you on the screen pictures of irido-cyclitis, which is a very common ophthalmic condition. The manifestations of it are always exactly the same, and the cause is equally certainly always, to seek. Every case of irido-cyclitis presents a typical picture, and each case demands a considerable amount of time for investigation. My colleagues will agree with me that often irido-cyclitis cases go blind under treatment ; in other words, we fail to check the inevitable disaster.

(Slide.)—Note the deposit on the back of the cornea, which is known, shortly, as " k.p.", or keratitis punctata. It is not an inflammation of the cornea at all ; it is a deposition on the back of the cornea of the exudate which springs from the ciliary body in cyclitis. Descemet's membrane becomes denuded of a certain amount of epithelium, and the deposit sticks to the raw places. There is a gelatinous exudate in the lower angle of the anterior chamber, which you often find in iritis, complicating the second stage of gonorrhœa, that is to say, the blood invasion. The pupil margin is adherent to the front of the lens, and is immobile. As the disease progresses, the aqueous becomes cloudy owing to an albuminous exudate ; the vitreous also becomes cloudy. Finally, iris adhesions take place completely round the pupil margin, to the lens behind, and the aqueous becomes caught. Such an eye becomes painful, and its tension considerably raised.

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Irido-cyclitis is due to three causes: the famous triad; sepsis, syphilis, tuberculosis. Having investigated all possible sources of sepsis, *e.g.*, teeth, tonsils, nasal cavity, genito-urinary passages, intestinal infections, you proceed to the Wassermann, the Kahn, and various other diagnostic tests. If they are negative, you turn your attention to tuberculosis and use tuberculin. The case whose picture I show you had one eye severely damaged, and when the other eye started I, as advised, sent the patient to Dr. Camac Wilkinson. He gave the patient tuberculin, and as a result this eye was saved, and she sees with it 6/18. The other eye was too badly damaged to have vision, though she still has it in her head.

Irido-cyclitis is a name given to a large number of diseases; one is the ordinary interstitial keratitis of congenital syphilis. The next slide shows a case of the latter; he was in a school clinic, and there was one patch of the disease in the upper quadrant of the cornea. This boy, amongst others, has been treated for me by Mr. Mills, and we have had some surprising results.

It has been the custom in this Hospital—introduced by Mr. MacMullen—to tap the anterior chamber in interstitial keratitis cases, in order to allow the aqueous, charged with inflammatory material, to escape, so relieving the eye of a serious handicap, and at the same time reducing the intra-ocular tension. When that has been done the nutrition of the eye improves. It is said by enthusiasts that if you inject into the patient, half an hour before the tapping, arseno-bouillon or some such substance, arsenic is found in the aqueous. What *cures* the patient is the relief of the intra-ocular tension and the voiding of the infected aqueous. I remember two cases, both treated for me by Mr Mills, in which both eyes were involved. Mr. Mills gave them a full anti-syphilitic course, and I tapped their anterior chambers to prevent infected material collecting and to relieve the tension. Both those patients now have 6/5 vision in each eye.

I show you now a picture of a late stage of interstitial keratitis. The empty vessels with dicotymous branching which you see remain for years. If you see such vessels, you know the patient has had, at some time, interstitial keratitis, and that may throw light on a diagnosis which would otherwise be obscure.

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Another point is the improvement which will accrue from taking patience and trouble. This patient was given massage of the cornea with yellow oxide of mercury, and treatment by diathermy in the Light department. The London County Council officers decided that no further treatment would be of service, and that he must attend a special school. I then said he was not fit to go to school; and then the L.C.C. sent him to a school whence he *could* have treatment at St. Thomas' Hospital, under Dr. Anwyl Davies. Then, after eighteen months, when he was over 16 years of age, he was discharged from the L.C.C. school for the partially-sighted, as he could see too much for that type of education.

Next I show you another type of interstitial keratitis; note the fungating appearance extending beyond the posterior corneal surface; this is a *discrete* interstitial keratitis. Every investigation proving negative, I sent the case to Dr. Camac Wilkinson, who treated it with tuberculin, and both eyes cleared.

I wonder how many of you are familiar with this book, of which I show you on the screen the title page—all of you, I hope—"Diseases of the Eye and Ear," by Jonathan Hutchinson, 1863. I show you also a plate from that book—Hutchinson's own pictures of the famous tooth deformities which bear his name.

What I want you to particularly carry away is the fact that interstitial keratitis, the discrete interstitial keratitis, and irido-cyclitis are all instances of panophthalmitis. Not only are the back of the cornea and parts of the ciliary body involved, but also the choroid. It is difficult to see these fundus lesions in their acute stages, because the vitreous is so opaque that they cannot be seen through it.

This (slide) is a boy who had whooping cough at school, and during convalescence he was allowed to read without restraint. When he arrived at Paddington for his holidays he asked his mother where she was, as he could not see her. Accordingly the boy was brought to me and I found his pupil margins adherent to his lens and his corneæ covered with keratitis punctata; nothing else was visible. As the condition cleared we were able to get his pupils dilated, and so could see his fundi. The maculæ were heavily involved, and you will see in the spots in other parts of the fundi that the vessels pass

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in front of the scars, showing that the condition is choroidal. If the vessel is obscured by the lesion it is choroido-retinal, but if it is not so obscured the disease is said to be choroidal. Both eyes were involved, and they remain seriously involved; but this is a very unusual case of irido-cyclitis and choroiditis associated with whooping cough. The choroiditis from this cause is the same as in a syphilitic case, except that in the latter the pigmentation and the atrophy of the retina are much more strongly marked. Mr. Fenton has a case of choroido-retinitis of syphilitic origin to show you, and that corresponds, except that the patches of pigmentation and the patches of atrophy are much more marked.

Interstitial keratitis belongs to a group of diseases which can be classed under the term "irido-cyclitis," having a definite set of signs and symptoms, and a definite termination unless interfered with by treatment. And please remember that irido-cyclitis is a pan-uveitis, involving the back of the cornea, iris, ciliary body, and choroid, as far back as the macular region.